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U.S. SENATE COMMITTEE ON HOMELAND SECURITY AND GOVERNMENTAL AFFAIRS SUBCOMMITTEE ON FEDERAL FINANCIAL MANAGEMENT, GOVERNMENT INFORMATION AND INTERNATIONAL SECURITY

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My name is Judith Solomon. I am a Senior Fellow at the Center on Budget and Policy Priorities. The Center is a non-profit policy institute in Washington that specializes in fiscal policy and in programs and policies affecting low- and moderate-income families. The Center does not hold (and never has received) a grant or contract from any federal agency.

I would like to thank the Chairman and the Ranking Member, Senator Carper, for giving me the opportunity to testify today and raise our significant concerns about the South Carolina Medicaid waiver proposal.

The Medicaid program is extremely important to South Carolina. It covers over 40 percent of all children in the state as well as 30 percent of all seniors, and it pays for half of all births. Medicaid provides important support for hospitals, nursing homes, and other health care providers in South Carolina. Except for some children and pregnant women, Medicaid beneficiaries in the state all have income at or below the poverty line. Medicaid provides a lifeline for low-income and vulnerable seniors, children, and people with disabilities.

While it is true that the cost of providing coverage to Medicaid beneficiaries is rising, the cost of providing health care to everyone is going up. Solutions to contain the costs of South Carolina's Medicaid program must be grounded on hard evidence to ensure that changes do not harm the hundreds of thousands of South Carolina residents who rely on Medicaid for essential health care services.

A sound proposal for reducing Medicaid costs would be tailored to the different populations served by the program as well as the characteristics of the state's health care delivery system. Rhetoric regarding consumer choice and empowerment is not enough to justify untested models of providing care such as the personal health accounts proposed for South Carolina. In evaluating proposals to apply models such as health savings accounts to Medicaid, the fact that the vast majority of Medicaid beneficiaries have incomes below the poverty line must be taken into account. They simply do not have resources available to pay for health care out of their own resources. A substantial body of research demonstrates that even modest cost-sharing significantly increases the

likelihood that low-income children and adults will not receive effective medical care and that making low-income Medicaid beneficiaries incur increased cost-sharing can endanger their health.

The South Carolina proposal is based on a series of faulty assumptions about Medicaid — that it costs more than private insurance, that it encourages people to use more health services than they need, and that Medicaid is administratively inefficient — that are demonstrably incorrect. While the state apparently believes that it can save money by replacing a public health insurance program with private programs, the evidence suggests that the state's proposal would increase the costs of providing health care to covered beneficiaries rather than reduce those costs. The waiver proposal does not include the beneficiaries or services that represent the lion's share of Medicaid expenditures, focusing instead on those whose care is already relatively inexpensive. Moreover, methods of risk adjustment used to determine rates for managed care programs cannot be used to predict the amount of money an individual will need to pay for health care costs.

Summary of the South Carolina Proposal

Under the South Carolina proposal, each Medicaid beneficiary would receive a capped personal health account to use to purchase health coverage. The state would deposit funds in an individual's account each quarter.[1] The amount of the deposits would depend on the individual's age, sex, eligibility category, and (in some cases) health status.

Individuals could use their personal health accounts in one of four ways:

- ***Self-directed care***: For individuals who choose this option, an amount would be deducted from their personal account to cover inpatient hospital care and "related" services; these individuals would purchase all other necessary health care services directly from providers at Medicaid fee-for-service rates with the funds remaining in their personal account. When the funds in the account were exhausted, these individuals would have to purchase any other needed health care services with their own money.

- ***Private insurance***: Individuals who choose this option would use the funds in their personal accounts to purchase coverage from private managed care organizations or other insurance companies and from pharmacy or dental plans. Any remaining funds in the personal accounts could be used for co-payments and deductibles, as well as for health care services not covered by the plan.

- ***Medical home networks***: Under this option, individuals would use their entire personal accounts to join medical home networks, which are groups of health care providers that would be organized to serve the state's Medicaid beneficiaries. Each beneficiary would be assigned to a primary care provider, who would be responsible for authorizing any needed services that the primary care provider could not supply. Like the private insurers in the option above, the medical home networks would be allowed to provide a more limited package of benefits than is currently offered by the state's Medicaid program.

- ***Group health insurance:*** Individuals who have access to group health insurance through an

[1] Balances in the account at the end of a quarter would roll over to the next quarter within a benefit year. According to the original waiver proposal, a portion of unexpended funds *may* be allowed to roll over to the following year.

employer could use their personal health accounts to help pay for the employee share of the premium. Individuals and families who choose this option would be subject to cost-sharing charges and benefit limits of the private plan, so children would not receive all the services guaranteed by the Early and Periodic Screening, Diagnostic and Treatment (EPSDT) program. Under EPSDT, children receive regular preventive health care and all necessary follow-up diagnostic and treatment services without any limitations, including services that may not otherwise be covered by a state's Medicaid program for adults.

Research Shows that Medicaid is an Efficient and Effective Program that is Less Costly than Private Coverage.

Medicaid provides comparable services at less cost than private insurance. A recent 13-state study contradicts the notion that Medicaid beneficiaries use more health care than they need, finding instead that adult Medicaid beneficiaries use about the same level of health care services as adults with private insurance.[2] A study of mothers in low-income families found similar results.[3] Among children, Medicaid has been found to provide better access to preventive services for children than private health insurance does; this is a desirable outcome that likely reflects the success of Medicaid in facilitating preventive services for children.[4]

Moreover, Medicaid is not costlier than private health insurance. A recent study by Urban Institute researchers for the Kaiser Family Foundation found that Medicaid's cost per beneficiary is lower than that of private insurance.[5] A separate study by Urban Institute researchers finds that Medicaid's per-beneficiary costs have been rising more slowly than those of private insurance in recent years.[6]

Most Beneficiaries Included in the South Carolina Waiver Proposal are Children and Parents Who Account for Only a Third of Medicaid Expenditures.

In South Carolina, 79 percent of Medicaid beneficiaries are children, parents with income below 50 percent of the poverty line, and pregnant women. The cost of providing Medicaid to these beneficiaries, who represent the vast majority of individuals in the program, constitutes just over one-third of the Medicaid program's cost.

Not surprisingly, the cost of providing long-term care services and other Medicaid services to seniors and people with disabilities who are eligible for Medicare and Medicaid — often called

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[2] Teresa Coughlin, Sharon Long and Yu-Chu Shen, "Assessing Access to Care Under Medicaid: Evidence for the Nation and Thirteen States," *Health Affairs,* 24(4):1073-1083, July/August 2005.

[3] Sharon K. Long, Teresa Coughlin and Jennifer King, "How Well Does Medicaid Work in Improving Access to Care?" *Health Services Research,* 40(1): 39-58, February 2005.

[4] Lisa Dubay and Genevieve M. Kenney, "Health Care Access and Use Among Low-income Children: Who Fares Best?" *Health Affairs* 20(1): 112-21, January/February 2001.

[5] Jack Hadley and John Holahan, "Is Health Care Spending Higher under Medicaid or Private Insurance?" *Inquiry,* 40 (2003/2004): 323-42.

[6] John Holahan and Arunabh Ghosh, "Understanding the Recent Growth in Medicaid Spending, 2000-2003," *Health Affairs* web exclusive*,* January 26, 2005

"duals" — accounts for about 40 percent of Medicaid spending in South Carolina. However, these individuals are not covered by the waiver proposal, and no changes would be made in how their care is managed or delivered. Overall, the waiver proposal would only encompass about 40 percent of what the state spends on Medicaid.

Given that the proposal mainly focuses on care provided to children and non-disabled adults, it is hard to see how the proposal would save money. The most recent national data on Medicaid expenditures from 2002 shows that the per person cost of Medicaid in South Carolina is just over $1,700 per year for both children and non-disabled adults under the age of 65. Even though the cost of providing Medicaid coverage to children and adults has increased somewhat during the last three years, Medicaid coverage still costs considerably less than care in the private market, where this year's average annual premium for employer coverage for an individual is just over $4,000 with family coverage costing almost $11,000 per year.[7]

Providing Medicaid beneficiaries covered by the waiver with "medical homes" may save some money and could increase quality and improve health outcomes. However, no waiver is needed to accomplish this, and in fact the state is already working on the laudable goal of increasing the number of medical homes for beneficiaries.

The South Carolina Waiver Would Substantially Increase the Administrative Costs of the State's Medicaid Program.

The latest draft of the waiver proposal notes that the new program is intended to limit unnecessary administrative costs, stating that nationally "over twenty cents of each healthcare dollar is spent on administration." Yet administrative costs for the Medicaid program average only 6.9 percent of total program costs. South Carolina does a particularly good job of keeping its administrative costs down. The state recently reported that its administrative costs were only 4.6 percent of total program costs,[8] well below the national average, and in 2004 the state's Medicaid expenditures grew substantially more slowly than the national average (5.8 percent versus 9.3 percent).

According to the most recent draft of the waiver proposal, the state would contract with:

- A vendor to develop and manage electronic cards for the personal health accounts;
- An enrollment broker to provide information and support to beneficiaries about their various choices;
- Managed care plans;
- Administrative service organizations to oversee the medical home networks;
- A dental benefits manager; and
- A transportation broker.

Every one of these new entities would have its own administrative structure. In addition, the state would have to provide funds to start up and administer the new option to allow beneficiaries to use their personal health account to contribute toward the cost of employer-sponsored insurance. A

[7] "Employer Health Survey: 2005 Summary of Findings," (Menlo Park, CA: Kaiser Family Foundation and Health Research and Education Trust).

[8] Medicaid and SCHIP Budget Estimates, Forms CMS-37 and CMS-21B, May 2005 submission.

recent review of similar programs in five states found that they only achieved savings if enrollment was high enough so that savings covered start-up and administrative costs. However, in most states enrollment was not high. Enrollment in the five programs that were examined ranged from 73 in Utah to 10,564 in Oregon.[9] To date, South Carolina has presented no information regarding its estimates of the numbers of families in Medicaid with access to employer sponsored coverage, so it is impossible to know whether the enrollment would offset the new costs.

A proposal to allow ten states to establish Health Opportunity Accounts for some Medicaid beneficiaries is included in the House Energy and Commerce Committee's reconciliation legislation. The proposal has some similarities to the personal health accounts proposed by South Carolina. The Congressional Budget Office has found that allowing these accounts would actually add to both state and federal Medicaid costs.[10]

With all the new costs that South Carolina would incur to implement its proposal, the historically low administrative costs of the South Carolina Medicaid program actually could increase substantially, taking away resources needed to provide health care services to beneficiaries and putting further pressure on already low provider payment rates.

South Carolina Does Not Have Enough Managed Care Plans or Medical Home Networks to Enroll Beneficiaries in All Parts of the State.

The South Carolina proposal is being touted as providing new choices for beneficiaries. It is claimed that new managed care plans will compete for enrollees. These assertions are made even though South Carolina lacks sufficient private insurers to handle the many Medicaid beneficiaries who would be directed into the private insurance or medical home network options. Looking at the state as a whole, *only 6.1 percent* of all South Carolina residents were enrolled in health maintenance organizations in 2004.[11] For Medicaid, South Carolina ranks 47th in the nation in managed care participation:

- Only 8.4 percent of South Carolina Medicaid beneficiaries are currently enrolled in Medicaid managed care plans.[12]
- There are only two Medicaid managed care plans in the state, and these plans currently cover just 28 of the state's 46 counties. [13]

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[9] Joan Alker, "Premium Assistance Programs: How Are they Financed and Do States Save Money?" (Washington, DC: Kaiser Commission on Medicaid and the Uninsured, October 2005).

[10] See Edwin Park and Judith Solomon, "Health Opportunity Accounts for Low-Income Medicaid Beneficiaries: A Risky Approach," (Washington, DC: Center on Budget and Policy Priorities, October 2005).

[11] Managed Care Penetration by State and Region, 2004 from InterStudy Competitive Edge: Managed Care Industry Report Fall 2004 at *http://www.mcareol.com/factshts/factstat.htm.*

[12] Centers for Medicare and Medicaid Services, "Medicaid Managed Care Penetration Rates as of December 31, 2004," available at http://www.cms.hhs.gov/medicaid/managedcare/mmcpr04.pdf.

[13] According to the original waiver proposal, expansion of managed care into three additional counties is awaiting approval.

- Adults with disabilities and children with special health care needs are not currently enrolled in managed care at all in South Carolina.

- South Carolina has only just begun to develop medical home networks.

Given the very low rate of managed care participation in South Carolina, the state's health care delivery system is not likely to be able to meet the needs of the many Medicaid beneficiaries who would choose (or be required to enroll in) private insurance or medical home networks.

In recognition of this problem, the South Carolina waiver proposal relies on the hypothesis that during the waiver period, "market forces will result in development of a number of as yet un-designed health plans to be offered to members." This rosy scenario — that a sufficient number of new private health plans will somehow arise to compete for Medicaid customers in an extremely short timeframe in a state with extremely low managed care participation — is not justified by the current marketplace for health care in the state.

Risk Adjustment Cannot Predict an Individual's Need for Health Care Services.

A fundamental question regarding South Carolina's proposal is whether the state would deposit sufficient funds in each beneficiary's personal health account to enable the beneficiary to purchase necessary health care services. The state says it would determine the amount of funding for each account through a process known as "risk adjustment." An individual's need for health care is inherently unpredictable, however, and no system of risk adjustment has ever been developed that can accurately predict what a specific individual will need for health care from one year to the next.

Under the South Carolina proposal, the state would begin by assigning each Medicaid beneficiary a "rate category" based on his or her age, sex, eligibility category, and (in some instances) health status. For each rate category, the state then would determine the *average* amount that Medicaid spent on beneficiaries in that category in a base year. That average amount, adjusted upward to reflect the increase in health care costs since the base year, would be deposited in the personal health account of each person in the rate category.

This process is similar to the way that states set per capita payments for their Medicaid managed care programs. Risk adjustment works relatively well in the managed care context because each plan enrolls a mix of individuals: while some individuals will cost the company more than the amount that it receives from the state to cover them, other individuals will cost the company less than that amount. Thus, if the plan receives a flat payment per person that represents average costs over all of its enrollees, the plan will come out behind on some people and ahead on others — and be able to cover its costs overall.

But using risk adjustment for personal health accounts, as South Carolina proposes, is very different. Since each account covers *only a single individual,* account funds *cannot* be shifted from people with relatively low health costs to people who turn out to have relatively high health costs. As a result, *some people will likely use up the money in their accounts and be unable to afford health care services that they need,* while at the same time, other people may have leftover funds in their account that they do not need. Because managed care plans can vary the benefit packages they offer as well as the premium an individual needs to join, even those choosing to enroll in a health plan may not have enough money to purchase the care they need.

South Carolina claims it will take individuals' health status into account when assigning them to rate categories. Yet this often will not be possible: many individuals will not have been on Medicaid long enough for the state to obtain a history of their usage of health care services.[14] Even when the state can determine an individual's health care needs, the accounts still will be insufficient for people whose costs are above average for those in their rate category. Furthermore, over the course of a year, some people who have used relatively few health care services in the past will become ill with chronic diseases such as cancer, heart disease, or diabetes; as a result, their health accounts will be too small to pay for the health care they now need.

Conclusion

The South Carolina proposal rests on giving new choices to beneficiaries, but what kinds of choices do Medicaid beneficiaries really want? While it does not appear that beneficiaries in South Carolina have been asked, a recent analysis of survey data helps answer the question. These survey results showed that having a choice of *providers* matters more to people than having a choice of *health plans*.[15] Efforts to increase the number of individuals with medical homes, efforts to increase provider participation, and better coordinate care to those with chronic conditions would increase consumer satisfaction and would likely decrease any unnecessary use of the emergency room and other services that may be occurring. The current proposal goes well beyond what is likely to improve quality and contain the costs of the program.

Thank you again for the opportunity to testify. I would be happy to answer any questions you may have.

[14] One large study found that 35 percent of beneficiaries were enrolled for a year or less. Pamela Farley Short and others, "Churn, Churn, Churn: How Instability of Health Insurance Shapes America's Uninsured Problem," (New York, NY: The Commonwealth Fund, 2003)

[15] Jeanne M. Lambrew, "'Choice' in Health Care: What Do People Really Want?," (New York, NY: The Commonwealth Fund: September 2005).